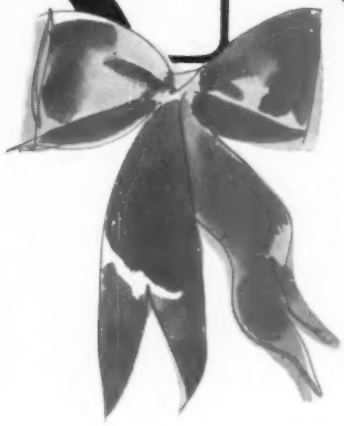
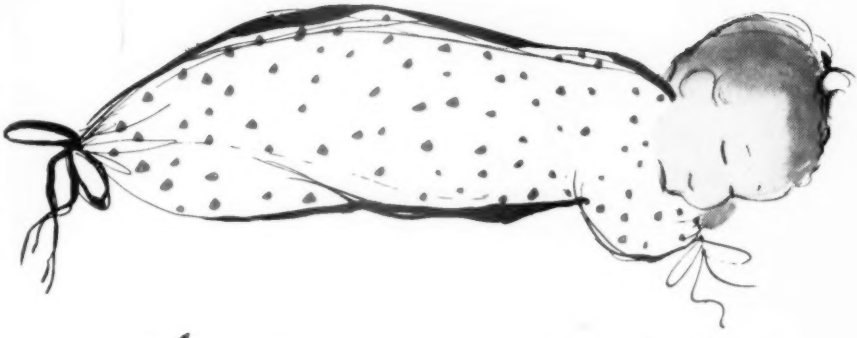
RN

DECEMBER 1960





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contents

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contents

DEPARTMENTS and SHORT FEATURES

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important for several reasons.

How patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—because there are so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine.

We know that a tall glass of orange juice is just about the best thing a patient can reach for when he or she raids the refrigerator. We also know that if you encourage this refreshing and healthful habit among patients of any age, you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest. RN

RN

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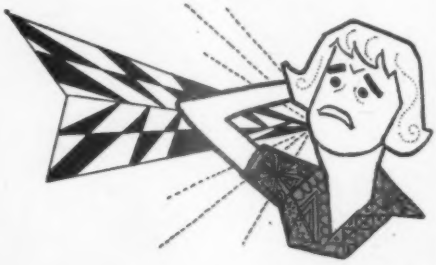
RN12

1. ANACIN is superior to aspirin or buffered aspirin...

2. In the management of tension headache



3. ANACIN possesses selective sedative action that eases tension, pressure as well as the pain

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effect in pain-reli

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RN letters

EDICINE IN BRITAIN

EAR EDITOR: We two have worked, bserved, and studied in Europe, ritain, and the U.S. We both gree whole-heartedly with the ritish R.N. quoted recently in our news columns.

The finest medical and nursing are *is* available in Britain. Con- der: Isn't it truly a triumph that egardless of creed, race, or finan- ial status, any person in Britain n have specialist attention as well s care by the general practitioner f his choice? Medicine there is deed a vocation and not a busi- ss!

V. Margaret Carter, S.R.N.
Susan Eckersly, R.N.
Abington, Pa.

OO SPECIALIZED?

EAR EDITOR: Often today's R.N. a dispenser of drugs or a veni- uncturer or an intramuscular harpshooter—rather than a bed- de nurse who has time to give ersonal attention to the patient.

Lest we push specialization too uch during training, let's consid- this line of thought: Is it wise r an R.N. to continue, year after ear, as a medication nurse, surgical supervisor, formula nurse, school nurse, etc.? Or, should she occasionally be given the chance to do a different type of nursing?

No doubt one can accomplish much by working within a small circle of vision. On the other hand, expanding the horizon of each nurse now and then may be just what nursing needs.

Let's give more thought to *total* nursing and make our voices heard in building a better profession.

Esther E. Garvey, R.N.
Appleton, Wis.

BACK TO A 'MIDDLE LINE'

DEAR EDITOR: I received my nurses' training thirty years ago. When I compare it with the kind given today, I'm glad I was graduated then and not now.

The first thing we were taught (and never allowed to forget) was: "The patient always comes first, even at the risk of your own life." Today the attitude of many nurses seems to be: "It's 3:30. I'm off duty!" And off they go, whether or not there's anyone around to take over.

I thoroughly believe in education. No doubt we needed to swing

away from the "strong-back-and-weak-mind" era that once prevailed. But let's not forget that more than "book learning" is needed in nursing education.

Perhaps we're nearing the end of that swing and will return to a sensible middle line. Let's hope so. We need to restore to nursing the ideal of T.L.C. that's much talked about but rarely seen today.

Edna Monroe, R.N.
Torrington, Conn.

ORAL SURGERY

DEAR EDITOR: I should like to correct the statement in your September check-list of medical specialists that "All oral surgeons are M.D.s."

The American Board of Oral Surgery gives this definition: "Oral surgery is that part of dental practice which deals with the diagnosis, the surgical and adjunctive treatment of the diseases, injuries, and defects of the human jaws and associated structures."

One of the requirements for certification by the board is membership in the American Dent Association or the National De tal Association.

Some oral surgeons *are* M.D but they have dental degrees well.

Melvin N. Blake, D.D
New York, N.Y.

RN *thanks Dr. Blake and the oth dentists who clarified this point f our readers.*

NOT MENIAL LABOR

DEAR EDITOR: Many people, noticed, have the false impressi that nursing is menial labo Among them are high school pr cipals, teachers, and counsel who influence the career choi of many girls.

We should see to it that th educators know what nursing cludes today and what capabili the would-be nurse needs. W making progress in this direct but we need to do much more.

Nancy Ann Snyder,
Westernport, Md.

STATEMENT REQUIRED BY THE AC
OF AUGUST 24, 1912, AS AMENDED B
THE ACTS OF MARCH 3, 1933, AN
JULY 2, 1946 (Title 39, United Stat
Code, Section 233) SHOWING TH
OWNERSHIP, MANAGEMENT, AN
CIRCULATION OF

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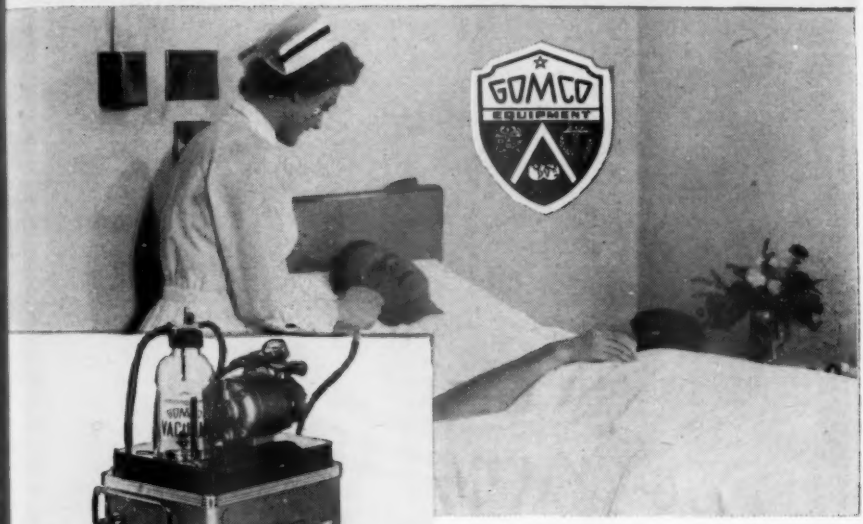
company as trustees, hold stock and se
ities in a capacity other than that
bona fide owner.

(Signed) William L. Chapman
Publisher

Sworn to and subscribed before me
28th day of September, 1960.

(Seal) Martha J. Pryor,
Notary Public, State of New J
(My commission expires October 24,

Busy Nurses Like Its Convenience!



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Designed with the busy nurse in mind, the 789 is saving valuable time and energy in thousands of hospitals. It is easy to clean, very simple to operate and requires a minimum of maintenance. Lightweight (only 16 lbs.), it is easily carried wherever the need arises. Its wide uses include general post-operative work, removal of mucous from throats of new-born and for polio cases. Accurate regulator valve and gauge give precision control of suction from 0" to 20" of mercury. Built to Gomco's uncompromising standards of quality. Depending on number of beds, every hospital needs from 7 to 14 of these units.

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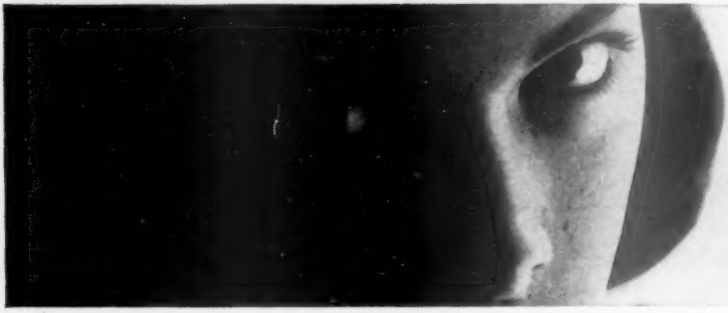
OPTIMUM NUTRITION: Providing all the normal dietary requirements plus a reserve for stress situations.

1. National Research Council Recommended Dietary Allowances, NAS-NRC Pub. 589 (1958).

NEW FAST HELP FOR PATIENTS WITH ACNE BIO-CLEAR™

Skin-toned greaseless fast-acting cream for topical sulphur therapy



Sulphur traditionally continues to be the most effective agent for local acne therapy. N BIO-CLEAR by Helena Rubinstein has been developed to supply the skin with an organic fo of sulphur, a form compatible with the skin's structure. Therapeutically, then, BIO-CLE represents an improved method of providing the healing benefits of sulphur in minimum ti

Sulphur benefits plus gentle antiseptic action: BIO-CLEAR Medicated Cream induces ge peeling, hastens shrinkage and drainage of comedones. Its antiseptic component helps to dest microorganisms, reduce danger of infection, and thus minimize scar formation from pustul BIO-CLEAR is well tolerated, and is virtually nonsensitizing. It contains no drastic peelers su as salicylic acid or resorcin.

Exceptional cosmetic advantages: The BIO-CLEAR formula has been skillfully complemen by the use of a masking cosmetic that discreetly conceals blemishes. The greaseless, cool fast-drying base in BIO-CLEAR is flesh-tinted to blend with the complexion. Make-up may applied over the cream if desired. For this purpose, a special liquid medicated make-up (Cl and Lovely™) has been formulated in seven shades by the Helena Rubinstein® Laboratories

Helena Rubinstein, Inc.

RN news

Vaccine Therapy Controls Staph, Study Shows

An anti-staph vaccine made from bacteria present in the patient to be vaccinated produced excellent results in 73 per cent of all cases treated and improvement in 18 per cent, says a research team at the Washington (D.C.) Providence Hospital. Its report covers sixty patients who received autogenous vaccine therapy for stubborn and recurrent staph infections.

In the past, says the team, use of stock vaccines for staph has produced poor results. This study seems to show that autogenous vaccines prepared by the new technique are superior.

'Total Asepsis' Urged in Catheter Drainage

Instead of taking it for granted that urinary tract infection is unavoidable in catheter drainage, give rigid asepsis a try, suggests Dr. Robert E. Desautels of Boston.

Writing in the New England Journal of Medicine, he emphasizes giving special attention to the three points in the drainage hookup where bacteria can enter: The urethral meatus, the connection between catheter and drainage tube, and the bottle end of the tube. His recommendations:

1. Thoroughly disinfect the meatus area (including the near-by catheter surface) at least once daily in male patients, two or three times daily in females, using a 1:1,000 benzalkonium solution.

2. Treat the catheter-tube connection as a sterile field. Disinfect the junction before disconnecting the catheter for irrigation. Do the irrigation aseptically. If the catheter is disengaged accidentally, cleanse the end of it carefully. Use a fresh drainage set when reconnecting catheter and tube.

3. Remember that bacteria can move upstream from the outlet end of the tube. Don't allow the bottle to fill to its top before replacing it with a fresh, sterile one. Don't let the end of the tube come in contact with collected urine or with the floor.

Foreign Doctors in U.S. Are on the Increase

The number of foreign physicians reported in training at U.S. hospitals increased by 13 per cent in

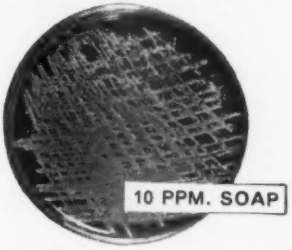
Continued on page 22

s aureus

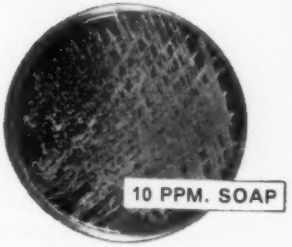
patients suggested

infection in hospitals!

In vitro tests demonstrate Dial's antibacterial superiority against Staph. Aureus



1. Ordinary toilet soap left this heavy Staph growth.



2. A widely used antiseptic soap showed little inhibition of Staph.

3. Dial Soap completely inhibited the growth of Staphylococcus aureus.

1355 W. 31st Street, Chicago 9, Ill.

1959-60 and has almost doubled since 1954, says the Institute of International Education. Some other statistics from the Institute's annual report for 1959-60:

¶ 9,457 foreign M.D.s from 92 countries were in training here.

¶ The Philippines led the 92 countries in representation with 2,319 doctors (24.5 per cent).

¶ The Far East led all world areas (38.5 per cent).

¶ 928 hospitals in forty-five states, D.C., and Puerto Rico reported having one doctor or more from abroad. Bellevue Hospital Center, New York City, headed the list with 87 foreign doctors.

OB Vacuum Extractor Replaces Forceps

A Brussels (Belgium) hospital is now using a vacuum-operated extractor cup for deliveries, instead of forceps. The cup is applied to the fetal head. It has been used in some 400 deliveries.

The extractor, says a report to Britain's Royal Society of Medicine, eliminates the need for anesthesia and

¶ Doesn't interfere with uterine contractions.

¶ Minimizes compression of the baby's head.

¶ Provides maximum space in the birth canal for the descending head.

¶ Permits directional control of the "pull" to conform with th direction of the head.

The vacuum cup further safe guards the delivery, says the re port, in this manner: If the 'pu becomes too great or is in th wrong direction, the cup auto matically detaches.

Shots in Baby's Buttock Seen as Grave Risk

Serious injury to the sciatic nerv with subsequent paralysis, may re sult from a single I.M. injection i the buttock. The risk is greate among the newborn—small pre mies, especially—than among ol er children and adults.

So says a Dallas, Tex., stud team in a report recently made t the A.M.A.

How obviate the risk? Abando the intragluteal site and give I.M injections in the midanterior thig the team suggests.

A.N.A. Hits Permissive Licensure of P.N.s

Practical nurses should be licens on a mandatory basis, not on permissive basis.

That's the stand the Americ Nurses' Association has taken the District of Columbia. The an A.N.A. spokesman recently o posed a bill that would permit but not require—P.N. licensure.

If a permissive law were pass said the A.N.A., an incompet

when intensive vitamin therapy is indicated...

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Each Kapseal of **THERA-COMBEX** supplies therapeutic doses of high potency Vitamin B complex and Vitamin C to accelerate convalescence after surgery or illness or to overcome specific vitamin deficiency states.

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person could do practical nursing as long as she didn't represent herself as an L.P.N. But if a mandatory law were passed, she would have to prove her competence and be licensed before she could practice.

The A.N.A. also recommended that the proposed law specify the qualifications necessary for licensure-board membership. These criteria should not be left to the judgment of D.C. commissioners, the A.N.A. said.

British M.D.s Recommend Nurse-Education Changes

British physicians, irked by the nurse shortage in England, are suggesting various plans to revise nurses' training, according to correspondence published in the British Medical Journal.

Nursing in England is done by state-registered nurses (comparable to R.N.s) and assistant nurses (comparable to P.N.s). At present, assistant nurses who want to become state-registered must "start over" by taking the regular course in nursing school.

Dr. H. W. Gallagher of Banbridge recommends these changes:

¶ Reorganize "the whole structure of the nursing profession" and shift the emphasis to the training of basic (practical) nurses.

¶ Abolish the present assistant-nurse classification and "replace it by a grade which would be the first stage on the way to . . . state registration."

¶ Call this new grade a state-registered nurse (S.R.N.) and the present registered nurse a state-registered staff nurse (S.R.S.N.).

These changes, the doctor believes, would attract more girls to nursing and would help save many small-hospital schools "which are now in danger of losing recognition."

The changes would "also bring the nursing profession into line with the medical profession, with a single register and the registration of higher qualifications . . . as they are obtained."

capsules

A new, 4-page leaflet called "Statement of Standards for Nursing Care in **Nursing Homes"** is available from the A.N.A., 10 Columbus Circle, New York 19, N.Y., for 10 cents . . .

Instead of exchanging **Christmas cards,** doctors in Schenectady, N.Y., are reportedly putting the money they'd spend into a medical-society trust fund for research and educational projects . . .

If a smear of cervical or vaginal mucus dries into star-shaped pa

MODILAC

A NEW PREPARED MILK FORMULA FOR MORE EFFICIENT NOURISHMENT

Looks and tastes like milk... offers nourishment comparable to that received by infants who are successfully breast fed. Immediately acceptable to the newborn, it helps the infant make an easy transition to fresh milk later.

Excellent protein and calorie utilization. A recent clinical study[1] indicated that infants receiving Modilac, in general, performed more efficiently than those of the control groups; weight increment from 2 to 16 weeks was highest; weight gain *per unit* of protein or *per calorie* consumed was greatest.

Modilac is "flash-sterilized." Browning and caramelization, the result of amino-sugar bonding and prolonged high processing temperatures, are markedly reduced. Destruction of heat-labile amino acids and vitamins is minimized.

The carbohydrate modifier in Modilac is high in dextrins, low in reducing sugars . . . provides "spaced" CHO assimilation.

Corn oil replaces butterfat, helps to maintain linoleic acid blood serum levels comparable to those of breast fed infants . . . assures optimal caloric efficiency.[2] Added vitamins A, C, D, B_6 and thiamine appropriately supplement the natural vitamin content.

GERBER® BABY FOODS FREMONT MICHIGAN

BABIES ARE OUR BUSINESS... OUR ONLY BUSINESS!®

1. Mosovich, Luis L., Pessin, Vivian and Lowe, Charles U.; Effects of Milk Composition on Baby Composition, AM. J. Dis. Child. **100**: 791-792, 1960.
2. Adam, Doris J. D., Hansen, Arild E. and Wiese, Hilda F.; Essential Fatty Acids in Infant Nutrition, J. Nutrition **66**: 555-564, 1958.

terns, the patient may have **breast cancer,** researchers at the National Cancer Institute report. The star-shapes probably are caused by hormonal imbalance accompanying the cancer, they add . . .

Length of the **average hospital stay** increased last year in general hospitals for the first time since 1946, says the American Hospital Association. The figures: 1958, 7.6 days per patient; 1959, 7.8 days per patient . . .

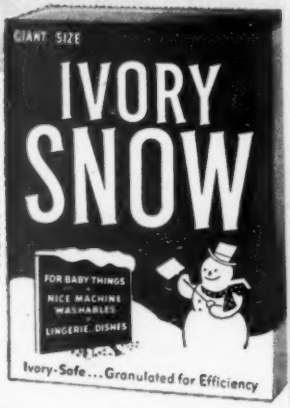
After March 6, 1961, **vitamin preparations** containing more than 0.4 mg. of folic acid per daily dose will be restricted to sale on prescription only, says the Food and Drug Administration. Reason: Greater amounts may mask the symptoms of pernicious anemia if a person has, or develops, this condition . . .

The American Public Health Association has added two volumes to its series of guides for helping **handicapped children.** The new volumes cover heart disease/rheumatic fever and epilepsy. A brochure, describing all eight books in the series, is available free from the association, 1790 Broadway, New York 19, N.Y. EN

Why should you recommend Ivory Snow for baby's wash?

Because it's as safe a soap as a mother n use . . . leaves diapers and baby clothes soft, ntle-clean . . . and completely free from irritating posits that can chafe tender skin!

Because it's as practical for mother as is safe for baby—the only soap that gives a sy mother Ivory-safety in the efficient granulated m she needs for today's washing machines!



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In answer to your many requests, Massengill Powder is now available in a convenient, aroma-sealed Packette which contains a measured, single dose. Of course, the formula is the same. This new, easy-to-use Packette is a time-saver at home and is also handy for traveling. Just open and mix—that quick!

Today's women recognize feminine hygiene as an integral part of health care. Massengill Powder has long been the leader among feminine hygiene preparations. Its clean, refreshing fragrance is acceptable to the most fastidious and it helps you to stay fresh and dainty.

Massengil! Powder is still available in 3-ounce, 6-ounce and 1-pound jars; Packettes are supplied in packages of 12.

Write for samples and literature.

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RN *literature and samples*

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DERMATOLOGICAL CONDITIONS: Desitin Ointment is suggested by its manufacturers as basic therapy for diaper rash, and as a soothing, healing application in wounds, burns, external ulcers and other skin ailments. Literature and a sample. DESITIN CHEMICAL CO. **M-2**

ANATOMICAL CHARTS: The circulatory, nervous, muscular and skeletal systems are shown in detailed, fully captioned color charts, included in a folder describing the products of KNOLL PHARMACEUTICAL CO. **M-3**

SHOE STYLES FOR NURSES: The latest Clinic Shoe creations are illustrated and described in a folder. Also supplied is a list of Clinic dealers in your area and a complimentary pair of white shoe laces to replace worn or soiled ones and keep your footwear spic and span. THE CLINIC SHOEMAKERS. **M-4**

FOR A TRIM FIGURE: The Relaxacizor system of figure control is based upon electronic stimulation of the motor points—the areas where nerves enter muscles. Offered is a copy of "Figure Primer" which tells the whole story. RELAXACIZOR, INC. **M-5**

UNIFORM FASHIONS: The fall and winter 1960-1961 style book of White Swan Uniforms includes 36 pages of all that's latest in professional attire for nurses. **M-6**

CONDUCTIVE SHOE COVERS: A folder describes a conductive rubber shoe cover which is simple to use and effective in providing a continuous ground for static electricity. The Condu-Steri shoe cover is a product of MELROSE HOSPITAL UNIFORM CO., INC. **M-7**

RECOVERY ROOM EQUIPMENT: Nurses who share responsibility for selection of surgical equipment can receive folders showing the Reliance Recovery Room Stretcher and other items of F. & F. KOENIGKRAMER CO. **M-8**

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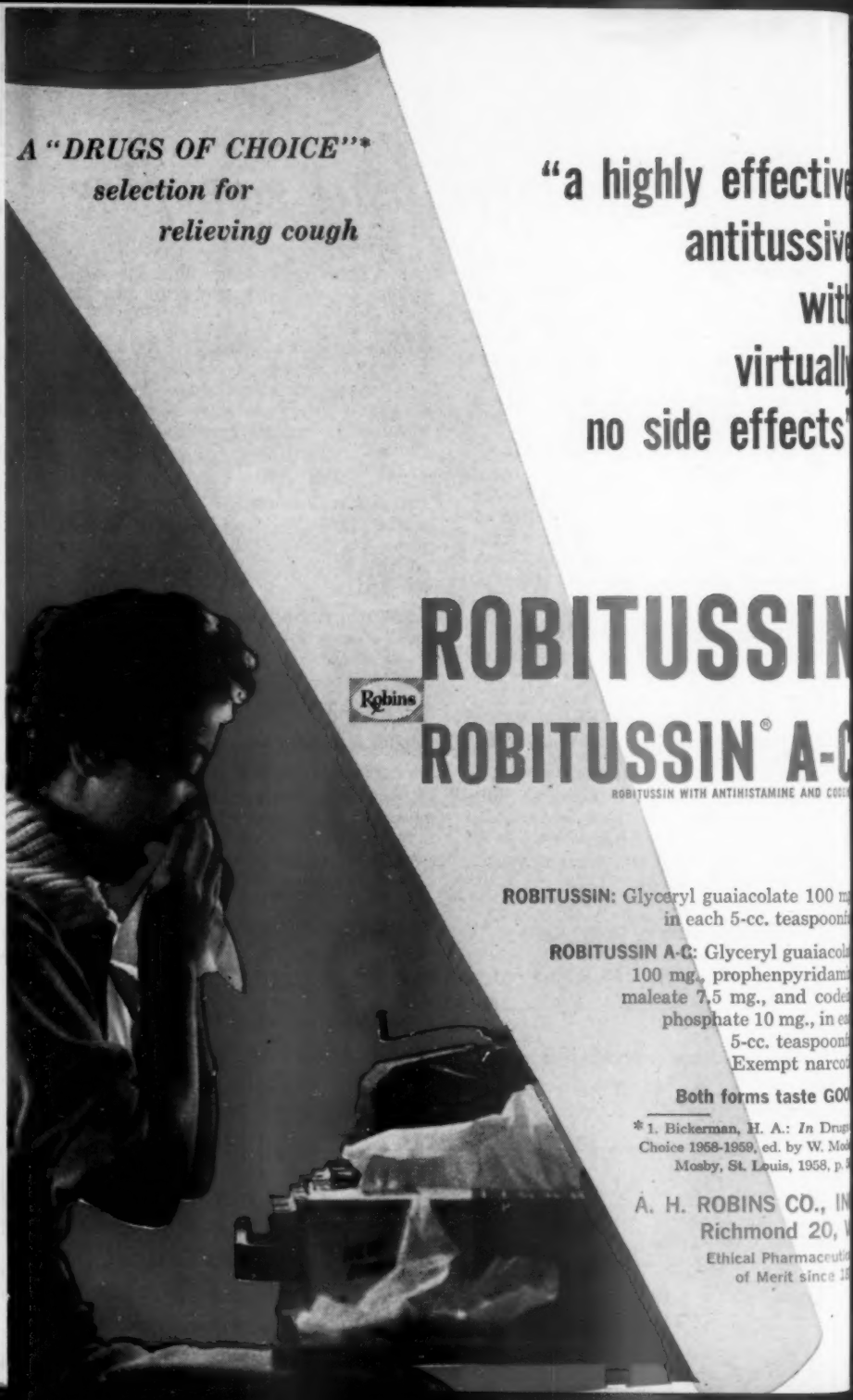
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relieving cough
"a highly effective
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* 1. Bickerman, H. A.: In Drug
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The Christmas Donkey

BY ELIZABETH T. HODGSON, R.N.

It's strange how an incident of many years ago will glow in your mind like the Christmas Star, forever bright and untarnished . . .

It was the night before Christmas in a military hospital. We nurses were filling bags for our 500 patients. Some of us had made fudge and fondant; and, fortunately, each batch had turned out well. We also had toys from the Red Cross—small cars, animals, clowns—nothing suitable for servicemen, really, but they added a festive touch.

Among my patients was a young fellow who gave us a great deal of trouble. He was surly and independent; and he didn't seem to care what happened to him. As I started to fill the bag with his name on it, one of the helpers handed me a tin donkey.

"He's the most stubborn guy I ever met," she said. "Let's give him this."

I was dead tired, so I dropped

the donkey into the bag without thinking.

Christmas morning we were up early. We tiptoed around, tying the bags to the patients' beds. Then we gathered together, lit our candles, and marched through the hospital joyously singing carols.

After breakfast I went on duty. As I approached our problem patient's bed, he called my name.

He was holding the gay bag in one hand and that awful toy donkey in the other. Tears were running down his cheeks. I felt smaller than a postage stamp.

Then his hand touched mine. "This is the first time I ever had a Christmas stocking," he said. He held up the donkey. "I'll bet they gave me this to kid me about my big ears."

"Oh, no, Jim," I found myself saying. "The donkey is a symbol of perseverance and fortitude. It's telling you that we believe in you. You've been very ill, but we know you'll fight your way back to health."

He started talking all in a rush. He told me about how he and his brother had been reared in an orphanage, and about how they'd been put out with a family that thought of only one thing: getting work from them. So at 16 he'd run away and joined the Navy. As far back as he could remember, he'd felt that he had to be hard-boiled.

After that, Jim was a changed lad and our most cooperative patient.

And I was a changed nurse.

Whenever a patient was unpleasant or mean, I seemed to see that little tin donkey lying on the bed. And I thought, "There's a reason. Be kind . . . Thank you, Jim." END

Never fear

"Miss Jones," the neurosurgeon asked the student nurse, "is my patient still getting hallucinations?" "Oh, yes, Doctor," she replied eagerly. "If you ordered them, I'm sure she's getting them."

—IRIS THOMPSON, R.N.

Drug Treatment of Gouty Arthritis

By Morton J. Rodman, PH.D.

Until recently, most people thought of gout as the result of overindulgence in rich food and alcoholic drink. Many still do. Some think it's a laughable affliction—as attested by the well-known stock-situation cartoon that shows a grumbling patient with a painful foot propped up on pillows.

It's true that overindulgence in food and drink *may* trigger an attack of acute gouty arthritis, typically manifested by a swollen, dusky-red big toe. But today we know that dietary indiscretions don't *cause* gout. Scientists have shown that it's a metabolic disease—a disturbance in body chemistry that may lead to acute and chronic gout and also to such difficulties as kidney stones and abnormalities of kidneys and blood vessels.

There's good evidence that the victims of gout (nineteen of twenty are men) produce abnormally large amounts of uric acid. Hereditary factors are thought to play a part in this overproduction.

Better understanding of the nature of gout has helped doctors devise more effective drug treatments for it. Many chronic gout patients can now function normally by taking drugs that prevent acute attacks. And the attacks themselves can be con-

THE AUTHOR *is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N.J., and a consultant to the U.S.P.H.S and other agencies.*

trolled more readily and effectively.

A number of powerful new drugs for ridding the body of excess uric acid have recently come into use. But, oddly, the keystone of gout therapy—a drug called colchicine—isn't new; nor does it have any clear-cut effect on uric acid metabolism.

History of Colchicine

Crude extracts of colchicum, the European autumn crocus or meadow saffron plant, were first used hundreds of years ago for gout. These proved undependable and often caused severe nausea, vomiting, and diarrhea. So they were gradually discarded. Today a pure crystalline alkaloid is available. And doctors have learned how to give it to get the best results with the least toxicity.

The patient subject to attacks of recurring gouty arthritis carries his colchicine tablets with him. At the first twinge of joint pain, he takes two tablets. He keeps on taking tablets at the rate of one tablet every hour or two until the pain stops or he develops gastrointestinal upset, usually diarrhea. In most cases, from three to six doses bring relief within twelve to twenty-four hours. (Paregoric with kaolin, or codeine, is added sometimes to allay diarrhea.)

Recently, colchicine has become available in a parenteral form that's claimed less likely to irritate the intestine. Injected intravenously, it rapidly relieves joint pain and reduces redness and swelling without causing stomach upset. However, the solution must be kept from leaking into subcutaneous tissues around the vein, for it's extremely irritating.

A Combination of Drugs

Occasionally when an attack flares up after smoldering untreated for several days, colchicine alone may not control it. Then the drug may be combined with one of the newer anti-inflammatory agents. For example, corticotropin (ACTH, et al.) sometimes terminates stubborn attacks when added to the colchicine regimen. Some doctors use phenylbutazone (Butazolidin) with good effect. But this must be given carefully.

The corticosteroids also help suppress acute attacks resistant to colchicine. They may be given by mouth or injected directly in

to an ailing joint. To prevent relapses when the steroids are withdrawn, the doctor may give colchicine at the same time.

Just how colchicine aborts acute gout attacks is still a mystery. It doesn't seem to lower the uric acid level. (Drugs that do lower the level don't stop the symptoms.) It doesn't act as a true analgesic either, for it deadens the aches and pains of gout only. It isn't useful as an antirheumatic against any other form of arthritis. In fact, its action is so specific against gout that the

Drugs Used for Gout

Entries on this list start with the official or generic names of the drugs, followed in parentheses by the trade names and/or synonyms.

Cincophen, N.F. (Atophan)
Colchicine tablets, U.S.P.
Corticotropin injection, U.S.P. (Acthar, Cortrophin, Solacthyl Inj.)
Corticotropin injection, repository, U.S.P. (Cortrophin Gel, Depo ACTH, El-Acorto Gel, HP Acthar Gel)
Corticotropin zinc hydroxide suspension, sterile, U.S.P. (Corticotrophin Zinc Suspension)
Cortisone acetate, U.S.P. (Cortogen Acetate, Cortone Acetate)
Dexamethasone, N.N.D. (Decadron, Deronil, Gammacorten)
Hydrocortisone acetate, U.S.P. (Cortef Acetate, Cortifan, Cortril, Hydrocortone)
Methylprednisolone, N.N.D. (Medrol)
Neocincophen, N.F. (Novatophan, Tolysin)
Phenylbutazone, N.N.D. (Butazolidin)
Prednisolone, U.S.P. (Delta-Cortef, Hydeltra Meticortelone, Prednis, Sterolone, Ulacort)
Prednisone, U.S.P. (Deltasone, Deltra, Meticorten, Paracort)
Probenecid, U.S.P. (Benemid)
Sulfinpyrazone (Anturan)
Triamcinalone, N.N.D. (Aristocort, Kenacort)
Zoxazolamine, N.F. (Flexin)

doctor may give it to help establish the diagnosis.

Colchicine plays an important part in treating chronic gout, too. Small nontoxic doses taken daily during symptom-free periods usually prevent acute flare-ups. Such prophylactic doses can be maintained indefinitely, for they cause no ill effects. Patients don't develop tolerance to them, either.

But colchicine has its limitations in quenching the flames of chronic gout. It can't prevent joint damage. Even when acute attacks are kept to a minimum, about half the patients develop deposits of uric acid salts, called tophi. As these stony growths enlarge, they may erode bones and joints, causing permanent crippling in some cases.

New Drugs for Gout

Fortunately for these tophaceous gout patients, a new class of drugs, the uricosurics, are now available to keep the crystal deposits from growing. Sometimes they even help dissolve deposits already laid down in bones, joints, and soft tissues.

Uricosuric agents promote the excretion of uric acid. They work on the kidneys' tubular cells to block reabsorption of urates that the kidney's glomeruli filter from the blood. This action lowers the level of uric acid in the blood and prevents it from being deposited in body tissues. Then, if the serum urate level stays near normal, the body fluids may in time dissolve old tophaceous deposits and excrete them.

Probenecid (Benemid), one of the uricosuric agents, increases uric acid excretion about 30 per cent above normal and rarely causes any toxic reactions. But some patients fail to respond to this drug. Others have to discontinue it because of gastric distress or allergic skin eruptions.

Two potent new agents, zoxazolamine (Flexin) and sulfinpyrazone (Anturan), are now getting a trial in gout patients. Used alone or in combination, they reportedly reduce serum urates in patients who have not previously responded.

The uricosuric action of both these drugs was discovered by accident. Zoxazolamine came into medicine originally as a skeletal muscle relaxant. Then doctors noted that patients taking it lost large quantities of uric acid in their urine.

Sulfinpyrazone was developed during attempts to improve phenylbutazone. The new synthetic, it was discovered, didn't possess the antirheumatic properties of the parent compound. But it did promote better uric acid elimination.

In fact, both drugs are so efficient in promoting uric acid elimination that they can prove dangerous unless certain precautions are taken. They may cause an unusually high concentration of uric acid to build up in the urinary tract. If the volume of urine is low, this acid may precipitate out as urate stones or crystals.

To prevent crystalluria and possible kidney damage, doctors have the patient drink large quantities of water. Some also give sodium bicarbonate to alkalinize the urine and thus increase the solubility of uric acid. For in-

legal pointer

QUESTION: *At our hospital we sign the nurses' notes with our initials. A friend says that at her hospital the first initial and last name are used. What's the law regarding signatures?*

ANSWER: A "legal signature" is, simply defined, that manner in which a person identifies himself in writing. Using the first and last name is the most common practice. But a briefer form is acceptable. All that's required to satisfy the legal obligation is (1) that the nurse be clearly identifiable by the form of signature used; (2) that she sign in the same manner on each and every occasion.

DO YOU HAVE A QUESTION *about some legal aspect of nursing? If so, send it to William A. Regan,* LL.B., *care of* RN. *He'll select questions for reply on the basis of their general interest to readers. No questions can be acknowledged or returned.*

creased safety, many M.D.s administer these potent drugs in small divided doses. This lessens the load of uric acid carried through the kidneys at any one time. The dosage is then adjusted to maintain the serum level of uric acid in a steady, normal state.

Authorities say that aspirin and other salicylates shouldn't be given with the uricosuric drugs. The reason: Salicylates in the urine tend to counteract the action of probenecid, sulfinpyrazone, and zoxazolamine. So, if a doctor wants to prescribe a pain-killer for a gout patient, he chooses something other than aspirin and its relatives—perhaps an analgesic of the phenacetin family.

Thanks to these new uricosuric agents and to colchicine, most gout patients can now be free of pain most of the time. Patients who once used to be laid up for weeks several times a year can now live normal lives —provided they take their daily treatment exactly as the doctor orders. END

Among the needy

Shortly before Christmas I made my regular visit to the first-grade room, wearing my uniform as usual. When I entered, Miss Bruto, the teacher, was saying what a joy it is to give to the less fortunate. She asked the children to watch for people who might be in need, and to report to her.

Later that day, little Jimmy came into my office. "Has Miss Bruto been to see you?" he asked.

"No, dear," I replied.

"She will be," he said mysteriously. "Merry Christmas, Mrs. Pratt!"

Next day I saw Miss Bruto in the cafeteria. I asked her what Jimmy had meant. She broke into laughter.

"As soon as you left the room," she explained, "Jimmy excitedly waved his hand. 'I know someone in need,' he said. 'Mrs. Pratt, our school nurse, has only one dress!' "

—JEWELL LESLIE PRATT, R.N.

You can help brighten the future for

Cleft-Lip and Cleft-Palate Babies

By Eugene T. McDonald, ED.D.

"Poor little darling!" you may say as you bathe the baby who was born with a cleft lip or a cleft palate or both.

Then you may think: "Suppose this were *my* child!"

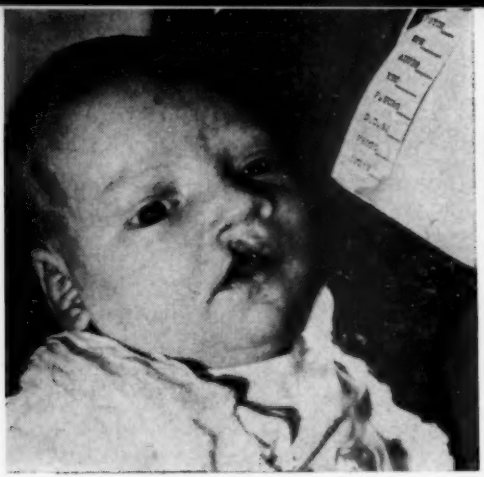
The thought alone is shocking. But for thousands of heartsick parents, the reality is infinitely worse.

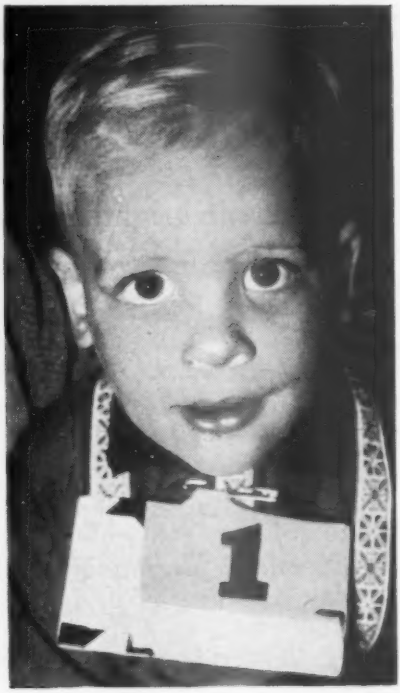
Each year about 4,000 babies are born with one or both of these congenital anomalies. In the past, the cleft-lip baby often was handicapped through life. And the cleft-palate baby, as he grew older, developed a blurred speech that even his family had trouble understanding.

Yet in most cases today, the future can be a bright one for these babies—thanks to advances in plastic surgery, to the development of dental prostheses, and to new techniques in speech therapy.

Unfortunately, many parents don't know this. And that's

THE AUTHOR *is director of the Speech and Hearing Clinic at Pennsylvania State University, University Park, and a past president of the American Association for Cleft Palate Rehabilitation. The article approximates a portion of his pamphlet, "Bright Promise," published by the National Society for Crippled Children and Adults, Inc., Chicago, Ill. (25¢).*





BEFORE AND AFTER: *Would you guess from the photo at the right that this boy was born with a cleft lip? Probably not. The photo above shows the defect as it looked before it was repaired by plastic surgery. As this boy nears school age, his future is bright. Even the scars left by the operation have faded so they're unnoticeable.*

where you come in: You can help change their despair to hope by explaining the whys, hows, and whens of available corrective measures.

The following facts about the causes and treatment of clefts will help you reassure such parents—particularly at the time their baby is born, when they need help the most.

* * *

The causes of lip and palatal deformities aren't yet fully understood. Apparently, prenatal conditions are responsible. For example, nutritional deficiency or acute infectious illness of the mother during the first trimester of pregnancy may interfere with the fetus' development. Even minor physical disturbances of the mother that wouldn't in themselves cause malformation may, in combination, have a deforming effect. Also, heredity seems to play a part, for 20 to 30 per cent of cleft-palate babies are born into families with a history of clefts.

Studies show that in the second month of fetal life, the upper lip forms from tissues that grow down from the nasal region and forward from the angles of the mouth. If anything interferes with the union of middle and side tissues, a cleft lip results.

In the third month, the sides of the upper jaw form and gradually grow toward the mid-line. Near the end of the third month, they fuse, creating the palate.

If anything interferes with this fusion early in the palate's growth, the resulting cleft extends the length of the palate. If interference comes later, a partial cleft results.

Parents who hear an explanation such as this often show only mild interest. The question they usually want answered more than any other (whether they ask it or not) is this:

"Is my baby normal in other respects?"

In most cases the answer is yes. Studies show that most children with cleft lips or palates are as normal in other respects as most children in the general population. For example: Their defect does *not* mean they lack intelligence, as some parents fear. They're mentally bright, average, or dull in about the same proportion as other children.

Feeding is often the next thing parents worry about. Fortunately, this tends to be less troublesome than they fear. A soft nipple with large holes is suggested for either the cleft-lip or cleft-palate baby. Pediatricians advise holding the baby in an upright position to prevent milk from running into his nose.

Correction of the cleft lip or palate is also of major interest. Here are the basic facts:

Cleft lip is usually corrected in a single operation as soon as the baby is strong enough to undergo surgery. In most cases, the operation can be done at six to eight weeks of age.

Closure of the cleft naturally leaves scars. But they become less and less noticeable during childhood and, in time, may hardly be visible.

Lip repair sometimes involves nasal structures in a way that may require rhinoplasty later to correct either the contour of the nose or conditions that interfere with breathing. Some corrections can be made before age 5; others are generally postponed till adolescence. *More*▶

Cleft palate may be corrected surgically or prosthetically. The choice of method depends largely on the width of the cleft and the character of the tissues.

Parents are naturally anxious to have the child's palate repaired as soon as possible. Sometimes, when surgery is indicated, the surgeon may operate when the child is between one and two years of age. In other cases, he may decide to postpone surgery until the child is older. In some cases, surgery may be contraindicated.

If a prosthesis is needed to reconstruct the palate, it can be provided by a dental specialist as soon as the child has teeth enough on which to anchor the appliance. In many cases, this means age 2½ to 3.

The prosthesis, or "speech aid," looks much like an upper denture without teeth (see photo). It's replaced about every two years till the child reaches adulthood.

Sometimes prosthetic correction is advised for the child's early years, with surgical repair later.

Other problems you can help parents to solve pertain mostly to cleft-palate children. These are the most prevalent ones:

▶ Speech problems.

Cleft-palate children aren't backward in learning to talk, as some think. Rather, because they can't properly form certain sounds, their speech is hard to understand.

Speech therapists stress these points for parents:

¶ Speak distinctly to help the child learn proper sounds.

¶ Don't use "baby talk." It will confuse him.

¶ Don't expect him to pronounce each word exactly as you do. His cleft won't permit that.

¶ Listen carefully and try to understand as many of his words as possible.

¶ Don't ask him to repeat phrases you don't understand. This may discourage him.

You can remind parents that speech therapy is often available to help the cleft-palate child after his deformity has been corrected. With this help, many children achieve normal speech by age 5 or 6.

▶ Hearing problems.

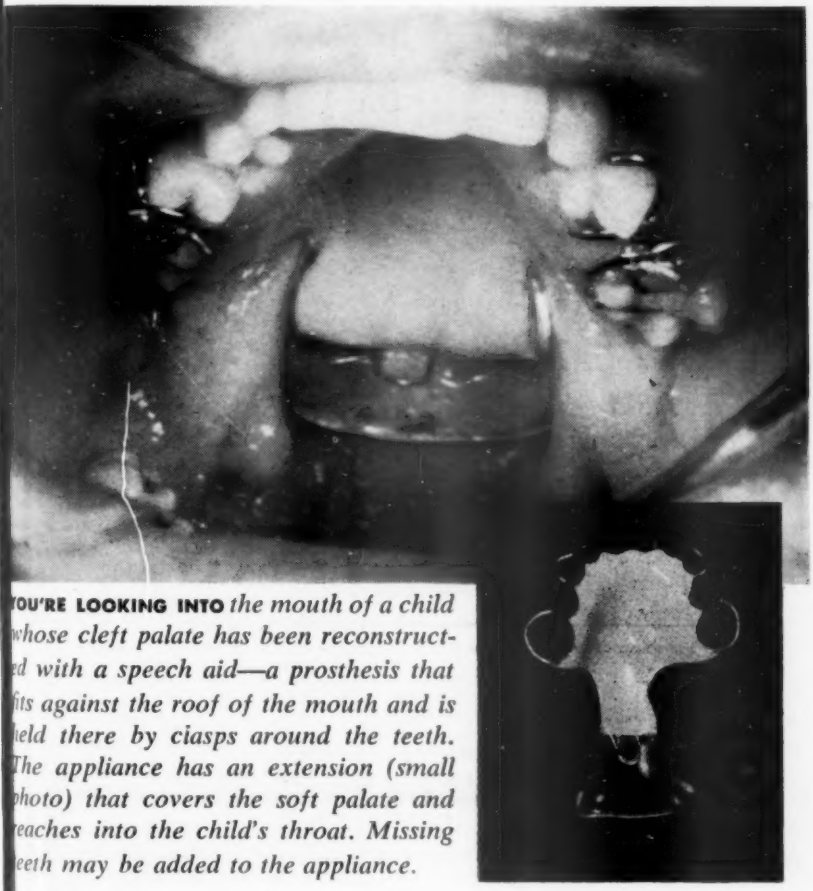
These usually are traceable to upper respiratory infections and faulty eustachian-tube function. They tend to be common among

cleft-palate children. Prompt medical attention for head colds (and for earache) is urged so that poor hearing won't aggravate the speech problem.

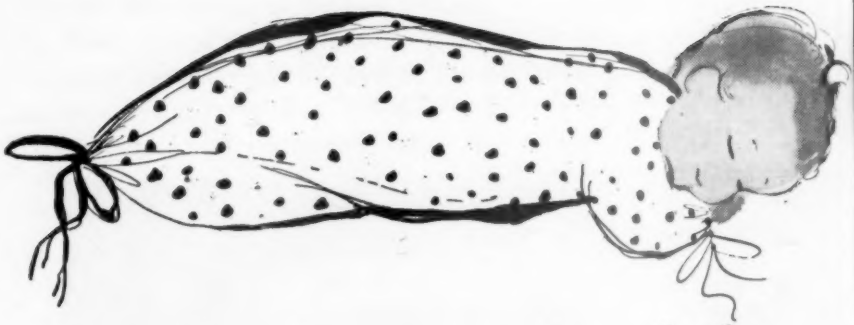
▶ Dental problems.

These can also complicate speech difficulties. So parents are urged to have their baby's first teeth (as well as permanent teeth) properly cared for.

To sum up: Parental cooperation is the key factor in all aspects of cleft correction. By getting parents to understand this, you can help them create a happier future for their handicapped babies. END



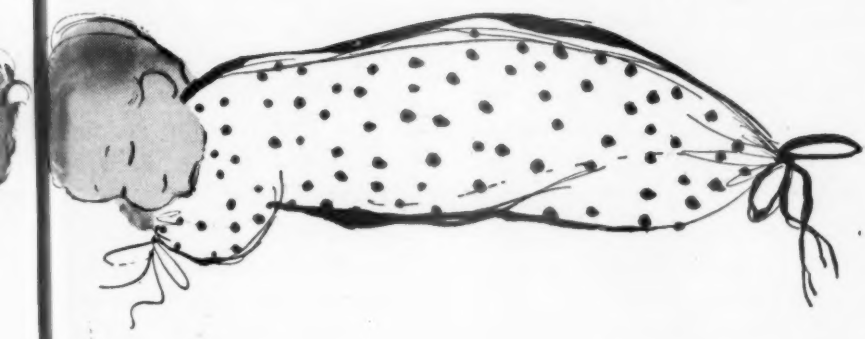
YOU'RE LOOKING INTO *the mouth of a child whose cleft palate has been reconstructed with a speech aid—a prosthesis that fits against the roof of the mouth and is held there by clasps around the teeth. The appliance has an extension (small photo) that covers the soft palate and reaches into the child's throat. Missing teeth may be added to the appliance.*



the first week of life

Every proved device and technique the R.N.s of this ultramodern OB department could suggest is used to safeguard newborns

By Charlotte Isler, R.N.



You probably remember vividly—as I do—the first delivery you ever attended. Afterwards, there was a warm, excited feeling as the delivery room staff shared the mother's joy when she saw her new baby.

Maybe it has been a while since you've given newborn care professionally. In the meantime, anxious questions from expectant mothers may have caused you to ask yourself: "Just how up-to-date is my knowledge of newborn care? Have delivery room and nursery practices changed much in recent years?"

Creighton Memorial St. Joseph Hospital in Omaha, Neb., can give you some interesting answers to the above questions. There, nurses enjoy using the latest procedures in an ultramodern obstetric and nursery department. At this carefully planned center, each infant receives individual attention throughout his crucial neonatal period.

I asked Jeanne Head, charge nurse in the labor and delivery rooms, to describe the physical facilities and how they help St.

THIS ARTICLE *is the last of three on maternal and infant care. The first (February, 1960) gave the procedure for assisting at an emergency delivery; the second (April, 1960) gave pointers for helping the newborn to breathe.*

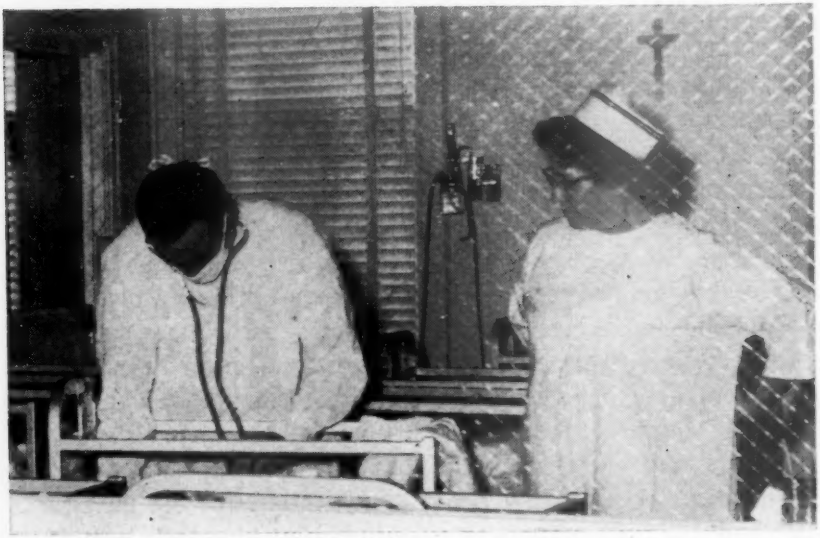
Joseph nurses give good newborn care.

"Our three delivery rooms are close to the labor rooms," Miss Head explained. "Two can be used for surgical deliveries. Thus, a mother in labor whose baby is in sudden distress (for instance, in abruptio placentae) can be delivered by Caesarean section much faster than if she had to be taken to the O.R. The few minutes' difference may save the baby's life.

"The nurseries are across the hall from the delivery rooms. Formerly we had one large nursery for forty babies. Now we have four nurseries for six infants each and two for nine infants each. In addition, there are two 'suspect' nurseries."

"Do you find that small nurseries are effective in keeping down contamination and cross-infection?" I asked.

"Definitely!" Miss Head replied. "We have other physical safeguards, too. Each nursery has its own equipment—for ex-



ANY SIGN OF ILLNESS *causes the baby to be hustled off to this "suspect" nursery. Here a doctor checks an infant as Mrs. Florence Hanrahan, head nursery nurse, looks on. If he's all right, she'll take him to his own nursery. If not, she'll transfer him to pediatrics.*

ample, refrigerator, bottle warmer, scales, stethoscope, and flashlight. None of these may be used in any other nursery.

"Each nursery has its own linen cupboard also. So nurses can restock each baby's bassinet without leaving the nursery. Everything a baby needs is kept in the drawers of his bassinet, including enough linen for twenty-four hours."

"That sounds like an ideal setup!" I said.

"We think so. The new nurseries incorporate many of the ideas submitted by our R.N.s during the planning stage."

"Will you tell me about your procedures, starting with the baby's birth?" I next asked. "I'm of course especially interested in the most recent advances in newborn care."

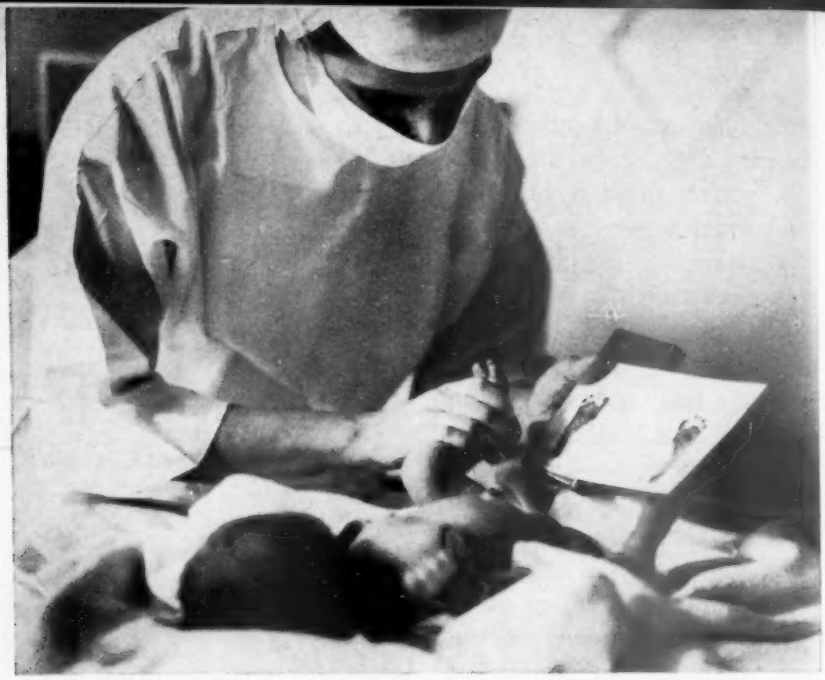
"Just try to stop me once I start!" Miss Head said with a smile. "Immediately after the baby is born, doctor and nurse observe and record the baby's condition. We use the Apgar rating scale* to evaluate the quality of heart rate, respiration, muscle tone, reflex irritability, and color.

"The doctor usually clamps the cord with two hemostats, cuts it between the hemostats, then lays the baby on a blanket on the instrument table. Next, he clamps the stump or ties it. If he clamps it, he uses a special cord clamp. If he ties it, he applies double ligatures of eight-inch umbilical tape.

"Generally, he cuts the cord one-half inch to an inch from the umbilicus. If the mother is Rh

*See "Helping the Newborn to Breathe," April, 1960, *RN*.

TO CUT DOWN TRAFFIC, *cupboards are built to open into the hall as well as into the nursery. While an aide replaces linens from the hall, Mrs. Hanrahan picks up a supply for each crib in the nursery.*



FOOTPRINTING IS DONE *in the delivery room. After cleaning the baby's feet with mineral oil, Jeanne Head, OB charge nurse, inks them and presses them against his identification card. She'll add his mother's fingerprint to this card, then do a second set for the baby's chart.*

negative, he cuts it one and a half to two inches from the umbilicus so transfusions may be given later, if needed.

"During immediate care, we place the infant in a heated crib, kept at 88 degrees F. We usually put him on his right side, in Trendelenburg position, to promote drainage and prevent aspiration.

"To prevent ophthalmia neonatorum, we put two drops of Neosporin ophthalmic solution in each eye, taking care not to touch the eyes with fingers or the dropper. We prefer this medication because it doesn't cause irritation, inflammation, or skin rash. (It's legally acceptable in Nebraska.)

"The circulating nurse continues to observe the baby closely as she footprints him for identification. She places a plastic identification bracelet around his ankle. This gives the hour of birth, date, mother's name, doc-

tor's name, baby's sex, and hospital number."

"When do you circumcise male babies?"

"If this is requested, we do it while the baby is still in the delivery room for these reasons: (1) There's less chance of bleeding when it's done immediately after birth. (2) It helps stimulate a sluggish baby. (3) It saves the baby a later trip from the nursery. (4) The wound heals more rapidly than if the baby were circumcised later.

"After circumcision, a sterile vaseline dressing is applied. This is changed at each diapering and removed twenty-four hours later. Usually, no further care is needed."

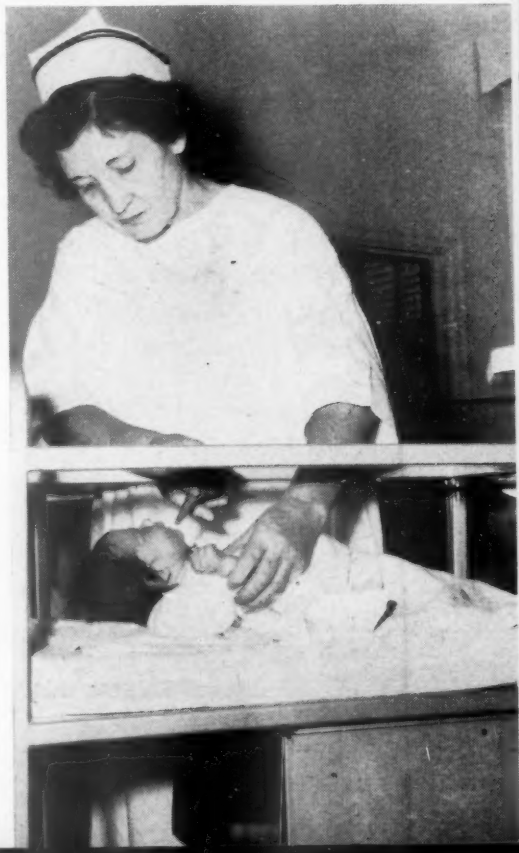
"What's the usual set-up for a circumcision?" I inquired.

"We use the following: A sterile set containing a Gomco clamp, three mosquito hemostats, scissors, thumb forceps, and probe; new sterile gloves for the doctor; a scalpel with a commercially sterilized, disposable blade."

Miss Head paused. "Here's Mrs. Florence Hanrahan, head nurse in the newborn nursery. Suppose you let her tell you about the care that starts after the baby leaves the delivery room."

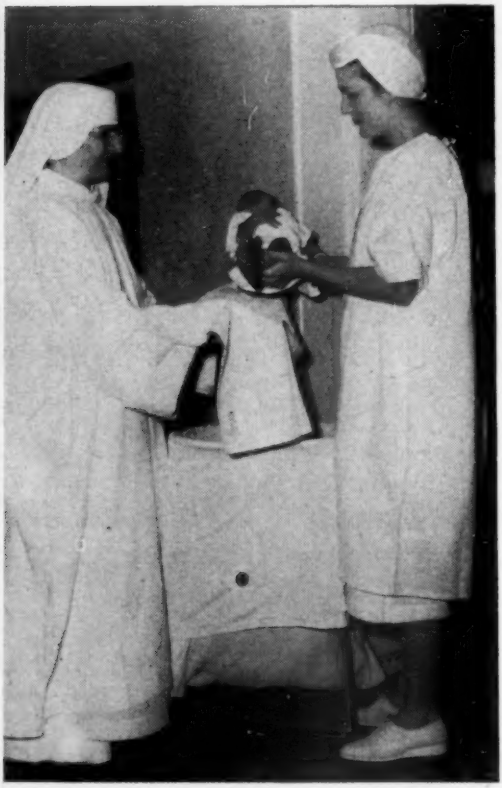
"Good!" I said.

Mrs. Hanrahan picked up the



IF MUCUS TENDS TO OBSTRUCT *the baby's airway, Mrs. Hanrahan puts a rolled mattress pad under his neck. This extends his chin, keeps his airway straight, relieves pressure on his trachea. Note the glass-sided crib, for observation, and the handy drawers that contain the supplies the baby needs.*

story: "When the baby is admitted to the nursery, we check his Apgar rating and his identification. Then we remove *excess* vernix with sterile cotton, and blood with sterile cotton and warm water. Finally, we wash his eyes and face with clear water and his head and torso with a pHisoHex solution containing 3 per cent hexachlorophene. This helps prevent skin infection."



"When do you weigh him, Mrs. Hanrahan?"

"That's next," she replied. "We also measure his length and the circumference of his head and chest. Then we take his temperature and dress him in a shirt, a diaper, and a receiving blanket. We place him flat on either side to promote drainage of mucus."

"What do you do if mucus tends to obstruct the airway?" I asked.

"We roll up a mattress pad and place it under the baby's neck," Mrs. Hanrahan explained. "We've found this to be very effective."

"I'm sure your new nursery equipment must lighten your work," I suggested.

"It surely does! More important, it helps protect the baby. For instance, the crib is glass-enclosed, thus permitting easy observation. The baby lies on a quilted cotton mattress pad. Under it is a linen mattress cover,

FEEDING TIME *finds the baby starting on his trip to see his mother by "individual carrier." Sister M. Corneliana will do the carrying while Margaret Crawford returns to her duties in the nursery.*

COVER GOWNS ARE REQUIRED *for all who enter the nursery. (Note supply on the rack at left.) After Miss Head has helped the visitor into his gown, she'll put on one herself before entering the nursery with him.*

which serves as a sheet. We change the pad and cover as necessary. The mattress itself is made of foam rubber and has a rubber cover.

"If a newborn seems to need extra heat or oxygen," Mrs. Hanrahan continued, "we may defer the weighing and bathing and place him in an incubator at once. We usually set the temperature at 88 to 90 degrees F., the humidity at 65 per cent. The oxygen flow rate is usually three to five liters, producing an O_2 concentration of not more than 40 per cent. Unless otherwise directed, we place the infant on his side. We remove him from the incubator when directed."

"How do you care for the cord?" was my next question.

"As you know, cord dressings once were common," Mrs. Hanrahan said. "But we don't use them now. If the cord is clamped at birth, the clamp is removed after twenty-four hours. But whether it's clamped or tied, we watch it carefully. If it becomes

IN TWICE-WEEKLY CLASSES *for new mothers, Mrs. Hanrahan (left) and Marguerite Determann, student nurse, teach formula preparation, diapering, other skills. Here they demonstrate how to bathe a baby.*

moist, we apply 70 per cent alcohol. If it bleeds or oozes, we use Adrenalin 1:1,000 and put pressure on the stump with the applicator.

"There's just one exception: If we think a baby will need transfusions soon after birth, we keep the cord moist with sterile saline dressings."

After a warm thanks and good-by to Mrs. Hanrahan, I talked next to Mrs. Maxine F. Jacks, assistant nursing director. The following is a summary of what I learned from her, Mrs. Hanrahan, and Miss Head about other phases of newborn care at St. Joseph:

The bath. Because a baby's skin is sensitive and easily prone to infection, rubbing is avoided. The pHisoHex bath given on admission isn't repeated until forty-eight hours later and each forty-eight hours thereafter.

Twenty-four hours after birth, and at forty-eight-hour intervals, the baby is cleansed with warm water and cotton only. A close watch is kept for any skin changes, such as a rash.

Diapering. Every effort is made to keep the baby dry. The diaper area is cleansed with sterile cotton and warm water. Powder isn't used, for it collects in creases and may cause irritation. If the area becomes red or inflamed, A and D vitamin-ointment may be applied.

Medications. These are no longer given routinely. But a doctor may order vitamin K intramuscularly after delivery or when the baby is admitted to the nursery. He may also order it if there's oozing from the cord or from the circumcision. The outer aspect of the thigh is the usual I.M. site.

Feeding. Sterile water may be given at first, twelve hours after birth. If bottle feeding is ordered, it's started twenty-four hours after delivery. Daytime feedings (except the 6 A.M. feeding) are given by the mother.

Nursing babies may be started earlier than bottle babies. The R.N.s give special encouragement to nursing mothers, for they know this may mean the difference between the mother's continuing to nurse or giving it up. Special breast cleansing is no longer done. A daily bath for the mother is considered adequate.

"Our usual feeding period is every four hours," said Mrs. Hanrahan. "But if a baby shows the need for it, he may be fed any time after three hours. Or, if he seems sleepy at feeding time, we may let him sleep for as much as an hour longer.

"Under this flexible schedule, the number of feedings during any twenty-four hours is usually the same as it would be under a rigid schedule. But mother and baby are much more contented."

Preventing contamination. In addition to the safeguards already mentioned, the following practices help protect the newborn:

1. The rotation nursery plan is used. Infants born the same day are admitted to the same nursery. No new baby is admitted until all in the nursery have been discharged. Then the nursery is cleaned thoroughly before another group is admitted.

2. A nursery worker who shows any sign of infection is kept out of the nursery until the infection clears up.

3. On entering the nursery, everyone does a two-minute hand wash with hexachlorophene. If a person handles an infant, he or she must do a hand

wash with soap before caring for a different baby.

4. Each nurse puts on a clean scrub gown each day. Scrub gowns never leave the department except for laundering in the hospital.

5. The nurse removes her cover gown before leaving a nursery; she *never* wears it in a different nursery.

6. When a baby is taken to its mother, the blanket in which it's wrapped is discarded before the baby re-enters the nursery.

7. Doctors and house staff wear cover gowns and masks in the nursery. Cover gowns for all nurseries are changed at eight-hour intervals.

8. Doctors wear canvas boots over their shoes when in the delivery room. The boots are laundered after each use.

"We're delighted with the improvements our new facilities have made possible," the three St. Joseph nurses told me. Each added, in her own words, expressions of pride and satisfaction that said, in essence: "Protecting the newborn during the first week of life is challenging and gratifying. We feel we're rewarded each time we pick up a healthy, contented baby." END

Something from Uncle Sam

The patient watched suspiciously as I listed her valuables for safekeeping. It was hospital policy that we shouldn't overappraise. So I described her diamond ring as "One white metal ring with clear stone." Her nationally advertised wrist watch with a gold band I listed as "One yellow metal wrist watch with a yellow metal band."

"Is there anything else?" I asked.

"Yes, indeed," she said coldly, handing me two $10 bills. "Just put down 'Two rather small pieces of green paper with a number in each corner and a picture in the middle.' "

—RUTH L. GEORGE, R.N.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

The Problem Is Aural

Confidentially, this has nothing to do with nursing. But RN*'s editors think you'll enjoy it as much as they did*

By Dorothy Patterson Gault, R.N.

Until lately, I haven't minded visiting the dentist. For one thing, while my teeth aren't particularly ornamental, they *are* durable. Secondly, my dentist is charming, perspicacious, and a brilliant conversationalist. At least I *think* he is. Furthermore, once I'm settled, his opening remark invariably makes me feel important.

"Never in all my years of practice," he says, "have I seen such gum recession as yours."

On several occasions he has even called in his assistant. "Did you ever see such gum recession?" he asks. She never has.

I remain quiet through all this reverse admiration. For I know I have absolutely no control over my gums. Early in our association the dentist assured me their shrinkage is a matter of heredity. Apparently my forebears were long on tooth and short on gum.

Once the dentist has established my uniqueness, he bypasses the usual trivialities and launches into some meaty sub-

ject such as: Moral Fiber of the Younger Generation. Weaknesses of the Public School Curriculum. Must a Young Man Sow Wild Oats?

Meanwhile, he attacks the stains.

I can only surmise that no one has ever informed the dentist that the processes he uses in cleaning teeth make it impossible for the patient to catch more than an occasional snatch of what he says. In fact, a session with him is tantamount to overhearing only one end of an animated telephone conversation—the one that convinces you the person at the other end is making some earth-shaking statements.

"You're the sort of individual . . ." my dentist begins, thus commanding my full attention. What follows is obscured by a motor-driven cleansing device that whines and grinds, filling my mouth with sound and a gritty substance I presume to be pumice.

When he removes his foot from the control pedal, the dentist's voice is strong with indignation: ". . . so I know you'll agree with me on this issue." Then, more tolerantly, he adds, "You may rinse now."

I rinse, spit, and towel, wondering if I do agree—and with what? Again I place my head against the rest.

"Unless we do this," he continues forcefully, "your children and mine will be irreparably injured."

I open my mouth to ask, "Do what?" But before I can articulate, he has resumed the scouring. He speaks with such an earnest expression that I strain after every word. All I manage to capture is: ". . . our duty to . . . I'm sure you understand . . . you may rinse now."

Real Top Secret

He has a genius for the provocative opening. His most memorable was uttered just prior to an onslaught on my right lower molars: "I wouldn't want to reveal this to anyone but you . . ." (Here he glanced over his shoulder.) Unfortunately, what followed was drowned out by more whirring and buzzing.

By the time he'd finished with the molars, he had disposed of that topic and was deep in another.

Ordinarily, I see the dentist twice a year. But once I met him

Continued on page 66

How to Teach an Old-Timer New Tricks

By Grace Spicer Stewart, R.N.

An R.N. is hired who has been away from nursing several years. She's given a brief orientation, or maybe a refresher, then put on the floor under your guidance.

Perhaps she's older than you and seems to resent instruction. She hasn't kept up with medicines and treatments and is a bit timid about both. So she gives you the old story that starts, "The nurse's place is at the bedside . . ."

She's slow at first. Then after time—just when you're hoping she may learn enough to help lighten your load—she quits.

You shrug, and welcome her replacement (if there is any). Then you go through it all again. Fortunately, this doesn't happen every time. Many inactive R.N.s *do* successfully make the transition back to professional-level nursing. And they do stay on. But, believe me, it isn't easy for them—especially for an older nurse. I know. I'm one of the "old-timers" who've relearned nursing.

The most heartening thing during my struggle was the patient, friendly help that hard-working career nurses gave me. So the least I can do is tell what helped me the most. Maybe you can use these pointers to ease the transition of other reactivated nurses—and, incidentally, ease your own job.

Here's my story:

It had been at least five years since I'd been inside a hospital;

the homecoming was pleasant. I happily sniffed the medicinal odors of Lysol and iodoform gauze. But when a courteous nurse showed me around, my spirits started to sink.

The changes in routine and in treatments were overwhelming. Even the medicine-closet labels were unfamiliar! My first panicky thought was, "Maybe I can just give bedside care."

I timidly suggested this to the superintendent of nurses.

"Mrs. Stewart," she said, "I admire your frankness. Now let me be frank, too. Either you're an R.N., able to assume an R.N.'s functions, or you aren't. Every R.N. in our hospital must learn, or *relearn,* all the latest techniques. We'll give you plenty of time, and we'll help all we can."

With *that* disposed of, I felt better. I knew what my goal was and I went after it zestfully, without any illusion that I could hide by the bedside.

Pointer: The wise nursing director lets the relearning R.N. know exactly what's expected of her. She also assures the newcomer that she'll be given the time and help to learn what she needs to know.

I'll never forget Mrs. Borghi Miilu, the personable, well-trai ed R.N. who took me under h wing. She was the soul of tact.

"I'm delighted to have yo company," she smiled. "Tw nurses working together are lot better than one."

The first day she gave th medicines, taking me along. Sh lent me a Physicians' Desk Re erence for homework.

The second day she let m prepare injections and admi ister them under supervisio Again, she did everything sh possibly could to make me fe at ease.

"I came along to introdu you to Mrs. Stewart," she to each patient. "Mrs. Stewart h a shot for you that will build u your blood" (or whatever the i jection was for).

Pointer: Instruction *tactfull given* will make the relearnin nurse your friend for life.

The head nurse must ha passed the word around. Near every R.N. in our small hospit (Baraga County Memorial i L'Anse, Mich.) joined in t help.

"Have you ever seen a fe enema?" one would ask. "It used to stop antibiotic diarrhea

Or, "I an in c rol. Wa Or, "L ter oxy ay you gain." Some ickled c had yea ights I carcely ged I w atch up ine.

ew R.N berthsid aby—o board a apt. Et rd, N.J ork. Sh urses w work a France

Or, "I'm going to give Phenergan in combination with Demerol. Want to watch?"

Or, "Like to help me administer oxygen in Room 33? That way you can get your hand in again."

Some days the perspiration trickled down my back the way it had years ago in training. Some nights I was so tired I could scarcely speak and so discouraged I was sure I could never catch up on five years of medicine.

"Just one more day," I would tell myself. Then a nurse would praise me for some little thing I'd done right. I'd feel lifted and keep going.

Pointer: Give the relearner constant help. Make it a team project. Be sure to add encouragement and praise.

For what seemed an endless time I was clumsy and nervous. One day a doctor had me help in the emergency room. I couldn't find a thing he asked for. After locating every item

---

'Berthside' Care Is Her Specialty

Few R.N.s will ever have to give "berthside" care to a premature baby—or any other patient—aboard a moving train. But for Capt. Ethel Liebowitz of Belford, N.J., it's all in the day's work. She's one of three Army nurses who have been assigned to work aboard ambulance trains in France and Germany. END

himself, he finally finished the procedure. Afterwards, he paused by the door.

"I couldn't *possibly* have managed without you," he grinned.

I laughed wryly. Then suddenly I realized I was still depending on others. Then and there I learned what was in the emergency room so I wouldn't be caught short again.

The nurses, in time, let me know that they considered me no longer a learner. For instance, one said: "You gave that injection skillfully. You don't need my help any more."

Pointer: See to it that the relearner doesn't continue to be dependent. Let her know when it's time she should be on her own.

Soon I was coming to work early, when I could manage, to set up my medicines; go through the files; familiarize myself with each patient's name, diagnosis, treatment, and physician. Often I stayed at night to check what I'd done and make sure it was correct and in order; and to go through the patients' cards again.

Pointer: This is the sign that will tell you your careful teaching and friendly guidance have paid off: The relearner will show new interest and confidence. She'll begin voluntarily to take over. By helping her, you'll have helped yourself. END

Hard to cure

The new patient was a little old lady of 86, almost totally deaf. She was screaming her history to me.

"I spent twelve years in Brooklyn Hospital and then two years in Grasslands," she yelled.

I leaned over and bellowed into her one usable ear, "What was the matter with you?"

She screamed back, "I was a nurse!"

—ELLIS M. MARKELL, M.D.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

1960 RN Award Winners

The top honor—and the $150 first prize—in the 1960 *RN* Awards competition goes to

• *Virginia Mello, Ashtabula, Ohio* •

Her article, "Nursing Is What You Make It," will appear in an early issue.

Honorable mentions—and Awards of from $25 to $100 each—go to the four R.N.s listed below. The articles by these winners either have been published (see month and year in parentheses) or will be published in the near future:

Doris A. Brickman, Glenview, Ill.
R. Claire Drayton, Doylestown, Pa. (7/60)
Suzanne Goren, Mill Valley, Calif. (9/60)
Constance Pomeroy, San Francisco, Calif.

The Editors congratulate the winners and sincerely thank the more than 200 contributors who participated in the 1960 *RN* Awards competition.

IF YOU CHEAT (JUST A LITTLE) ON YOUR DIET

1

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WHAT'S NEW IN *Drugs*

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—MORTON J. RODMAN, PH.D.

The Problem Is Aural

Continued from page 56

in the street, near his office. Though obviously in a great hurry, he stopped and grasped my arm.

"You *did* follow my suggestion on that school-policy matter, didn't you?" he demanded.

To my horror, I found myself nodding assent without the vaguest notion of what he meant.

He released me, smiled, and added, "Contacting the board would have been far too time-consuming." Then he rushed off, flinging over his shoulder the compliment: "I knew I could count on you."

This encounter forced me to a decision. I realized I must take steps lest some real disaster occur because I wasn't receiving the dentist's messages. I resolved that at our next meeting I would stand on my two feet and straightforwardly explain, "Doctor, I think you should know I'm unable to hear while you're cleaning my teeth." *More*

THE PROBLEM IS AURAL

What happened? The dentist's assistant summoned me to a cubicle as usual, flourished a bib, and ordered me to sit. Back in the waiting room there was standing room only. Tots snarled and snapped at their parents. Adults peevishly vied for the later copies of "The National Geographic" and "The Organic Farmer." Defying the assistant and returning to the waiting room would have lowered me to the level of a recalcitrant child. So I sat.

She offered me a tissue and suggested I remove my lipstick. (For some reason, this maneuver always puts me on the defensive. She doesn't say I'm a painted hussy, but the implication is there.) Still, I clung to the hope I might yet get at the dentist before he got at me.

The whine of the drill penetrated the partition. Then it stopped. A moment later, the dentist appeared, flashed his welcoming smile, and snatched up a viewing instrument.

"Doctor—" I began.

He thrust the mirror into my mouth and beckoned to his assistant. "Just look here," he said reverently. "Have you ever seen such gum recession?"

She never had. END

Subject Index to

RN

January Through December, 1960
(Vol. 23, Nos. 1-12)

Back copies of *RN*, containing the articles and items in the following list, may be purchased, as long as the supply lasts, at the established back-copy price of 25 cents each. Individual listings show title, date of issue, and page number. Italics denote full-length articles of one page or more; other listings refer to news items and short features of lasting interest.

ANNUAL SUBJECT INDEX

on the pathogenesis of pyelonephritis:

"An inflammatory reaction here [renal papillae] may produce sudden rapid impairment of renal function. One duct of Bellini probably drains more than 5000 nephrons. It is easy to see why a small abscess or edema in this area may occlude a portion of the papilla or the collecting ducts and may produce a functional impairment far in excess of that encountered in much larger lesions in the cortex."[1]

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References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. **102**:32, 1958. 2. Freedman, L. R., and Beeson P. B.: Yale J. Biol. & Med. **30**:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. **30**:341, 1958.

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[1]Brusch, C.A., et al.: Md. State Med. J.; 5:36, 19

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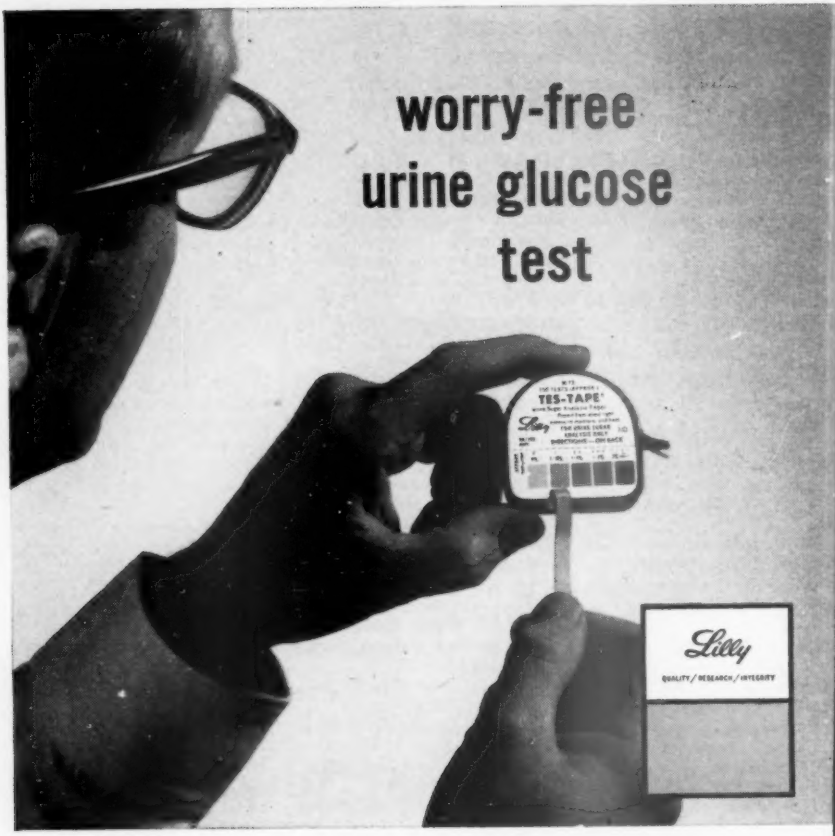

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1. Whipple, R. L., Jr., and Bloom, W. L.: J. Lab. & Clin. Med., *36*:635, 1950. 2. Parker, A Textbook of Clinical Pathology, Ed. 3, p. 568. Baltimore: The Williams & Wilkins Com 1948. 3. Seltzer, H. S., and Loveall, M. J.: J. A. M. A., *167*:1826, 1958.

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DIRECTOR OF NURSING SERVICE: Responsible for management of the nursing service of an active 225 bed JCAH accredited children's hospital. Affiliating agency for professional and practical nurse students. B. S. degree required, Master's degree preferred, experience desirable. Salary commensurate with qualifications. Apply Director of Nursing, Children's Hospital, 2125 13th St., N. W., Washington, D. C.

FLORIDA OPPORTUNITY: The newest Hill Burton hospital of 135 beds, on Florida's beautiful Gulf Coast. Escambia General at Pensacola offers to the nursing profession a unique opportunity, ideal living conditions and m
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open December 1st in fully accredited, f
new Kansas hospital. Good personnel pol
including liberal holidays, vacation,
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annual increases to $320. Apply Directo
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tor, Highland Park Hospital Founda
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GENERAL DUTY NURSES: $410 to $45
mo., 500 bed hospital located 17 miles
Detroit, County Civil Service, good pers
policies including 12 days vacation, 12
sk. lv., and 11 pd. holidays per year. A

Director of Nursing, General Hospital Division, Wayne County General Hospital, Eloise, Mich.

GENERAL DUTY NURSES: All depts. in 250 bed general hospital, liberal personnel policies, 40 hr. wk., other fringe benefits, rooms available in Graduate nurses residence if so desired. Apply Director of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

GENERAL DUTY NURSES: J.C.A.H. accredited, 99 bed hospital midway between Los Angeles and San Francisco. Salary depends upon experience and qualifications. Rooms available in modern nurses' residence $10 per mo., 40 hr. wk., 15 days vacation. Liberal sick leave, 12 holidays. Social Security Benefits. Write: Superintendent of Nurses, Tulare County General Hospital, Tulare, Calif.

GENERAL DUTY NURSES: 84 bed hospital, finest equipment 40 hr. wk., very liberal personnel policies, pleasant working environment, rotating shifts, salary range $337.99 to $457.59 mo., $20 evening and night differential. Atomic Energy Project, not civil service. Write Director of Nurses, Los Alamos Medical Center, Los Alamos, N. M.

GENERAL DUTY NURSES: 135 bed hospital on San Francisco Bay. Rooms available. Opportunity for advanced education in the area. Salary range — monthly — $345 to $390. $20 shift differential, $10 added for experience OB and OR. Director of Nurses, Alameda Hospital, 2070 Clinton Ave., Alameda, Calif.

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GENERAL DUTY, SURGICAL AND PEDIATRIC NURSES: 276 bed gen. hosp, in residential suburb of Chicago. 40 hr wk, cash salary and live in, $285 day duty, $315 PM

duty, $310 night duty plus private room in new nurses residence, 3 meals per day and free laundry of uniforms. Cash salary and live out, $330 day duty, $360 PM duty, $355 night duty plus 1 meal and free laundry of uniforms. Low rental apartments available for married nurses. Planned service increases at regular intervals. Many other benefits. Write Personnel Director, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: 350 bed hospital; openings on all services; salary $380-425 per mo., rotating shifts; permanent positions on evening and night duty available; 2 wk. vacation after one yr., of service; 6 holidays; 7 sk. days first year, 1 day per mo., thereafter; hospital contributes to Blue Cross coverage. Write: Margaret M. Shurgot, R.N., Director of Nursing Service, 2131 West Third St., Los Angeles 57, Calif.

GRADUATE NURSE ANESTHETISTS: Desire two (2) graduate nurse anesthetists from approved school with membership in the American Association of Nurse Anesthetists. Salary $400 to $525 depending upon qualifications. One (1) month vacation, two (2) weeks sick leave. Board, room and laundering of uniforms without cost. Forty hour week with day off before and after night call. Please contact Dr. Donald H. Haselhuhn, Director of Anesthesia, Harrisburg Hospital, Harrisburg, Pa.

GRADUATE NURSES: For a 60 bed general hospital in a growing frontier community. Start-salary $325 per mo. for 40 hr. day wk. On duty meals and uniform laundry furnished. 6 holidays per yr., and up to 12 days per yr. sk. lv., 2 wks. pd. vacation, low cost modern residency for single girls. Southwest Memorial Hospital, 925 So. Broadway, Cortez, Colo.

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GRADUATE NURSES: Opening of new main building has created attractive positions for staff nurses in medical, surg., obstetric and pediatric divisions of 450 bed non-sectarian acute general hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Apartments available in immediate neighborhood. Apply Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 E. 105th St., Cleveland 6, O.

GRADUATE STAFF NURSES: 151 bed hospital with school of nursing, situated 3 blocks from Atlantic Ocean. Beginning salary $300, evening duty bonus $20, night duty bonus $30 Apply Director of Nursing, Southampton Hospital, Southampton, N.Y.

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GRADUATES: Mercy College of Anesthesiology offers an 18 mo AANA approved course to graduates of accredited schools of nursing. Write: Director, Anesthesia Dept., Mount Carmel Mercy Hospital, Detroit 35, Mich.

HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy and old-fashioned warm care of patients with cancer and allied diseases. Teaching and research center offers valuable experience. Adequate staff of top nurses maintained. University-affiliated inservice education; access all NYC educational programs. Good basic preparation required; learn specialty here where patients receive active surgical-medical-radiation therapy. Not a chronic disease hospital. Effective September 1960, Staff Nurses; day $366-409 month; evening $421-$464; night $410-$453. Head Nurses, $422-$467. 4 wk. vacation; 1½ pay for overtime; Blue Cross pd., uniforms laundered. Minimum rotation. Furnished apartments available through Housing agent. New 20 story apartment house overlooking East River opens December 1961. Suture nurses: base salary plus ½ pay for on-call.. Mary Connolly, R.N., Acting Director of Nursing, Memorial Hospital, Memorial-Sloan-Kettering Cancer Center, 444 E. 68th St., New York 21 ,N.Y.

IMMEDIATE OPENINGS: For Head Nurses in O.B., nursery, medical and surgical depts., 3-11 and 11-7, starting salary $315, also scrub nurses in O.R., 7-3, starting salary $310. New 200 bed hospital enlarging to 400 beds. Contact Supt. Nurses, Medical Center Hospital, P.O. Box 1631, Odessa, Tex.

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INSTRUCTOR IN PEDIATRICS: Large city hospital, $375 per month. Write: Director of Nursing, General Hospital, Kansas City, Mo.

INSTRUCTOR-MEDICAL AND SURGICAL: Formal and Clinical Teaching, NLN full accreditation. One class yearly or approximately 40 students. B.S. degree and teaching experience required. Liberal Personnel Policies, salary based upon background. No nursing service responsibilities. 500 bed hospital. Direct transportation to New York City in 35 minutes. Write to: Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

INSTRUCTOR-SUPERVISOR, IN-SERVICE EDUCATION: For orientation and supervision of practical nursing students, and orientation of nursing service employees. Should have B.S. degree in nursing education or equivalent, and minimum of two years experience in two of the following positions: instructor, assistant instructor, head nurse. 40 bed private general hospital with school of nursing. Contact Personnel Director, Milwaukee Hospital 2200 W. Kilbourn Ave., Milwaukee 3, Wis.

INSTRUCTORS: Fundamentals of Nursing, Obstetric Nursing. Immediate opening. Bachelor Degree and experience in Teaching required. Liberal personnel policies. Admit

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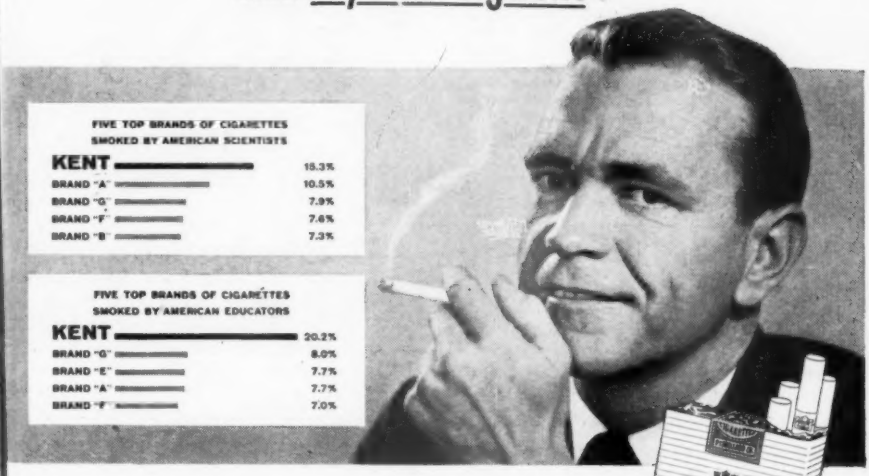

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class a yr., 3 yr., diploma program, N.L.N. accredited. 184 bed hospital, 60 students. Apply Director of Nurses, Helene Fuld Hospital, Trenton, N. J.

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INTENSIVE CARE NURSES: $400+ immediate openings, accredited. Morningside Hospital, 8711 S. Harvard Blvd., Los Angeles 47, Calif.

LICENSED PRACTICAL NURSES: Because we are friendly people, it is fun to work in the preferred department of a 200 bed J.C.A.H. approved general hospital with N.L.N. accredited school and opportunity for advancement with orientation provided. Liberal personnel policies. Ideally located on 60 acres of lawn and wooded area. Convenient transportation. For details contact Director of Nursing, Broadlawns Hospital, Des Moines 14, Iowa.

LOS ANGELES COUNTY GENERAL HOSPITAL SCHOOL OF NURSING: Has a position open for an R.N. with a Master's degree in the social sciences and teaching experience in Psychology and Sociology. Salary begins at $545 per month. Write for further information to: Betty Hartwig, R.N., Los Angeles County General Hospital, 1200 North State St., Los Angeles 33, Calif. Box 1311.

MALE NURSE: (a) Direct nursing service 2000 bed psych. hsp. M.W. $6-9000! (b) Direct 110 bed hsp. in M.W. penal institution near lake resort; $6000 plus rm. bd. RN 12-6, Burneice Larson, The Medical Bureau, Inc., 900 N. Michigan Ave., Chicago 11, Ill.

MEDICAL AND SURGICAL CLINICAL INSTRUCTOR: Diploma school affiliated with Community College. B.S. degree and teaching experience required. Good personnel policies. JCAH accredited 210 bed general hospital. Apply Director of Nursing, White Plains Hospital, White Plains, N.Y., Telephone WH 9-4500, Ext. 255.

MEDICAL-SURGICAL SUPERVISOR: Administrative. 500 bed voluntary hospital. Degree and satisfactory experience required. Salary dependent on education and experience. Liberal Personnel Policies. Direct transportation to New York City in 35 minutes. Write to: Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

MEN: Wanted for nursing positions at Los Angeles County General Hospital. Positions are open at $375 and $417 month. For further information write to: Betty Hartwig, R.N. Los Angeles County General Hosp., 1200 North State St., Los Angeles 33, Calif. Box 1311.

NEW MEXICO: Needs Public Health Nurses. Excellent salaries, fringe benefits. Write: Merit System, Box 1058, Santa Fe, N.M.

NURSE ANESTHETIST: To work with four anesthesiologists and one nurse in private group. 280 bed hospital in town of 40,000, 7 miles from Hartford. No night or holiday calls. Starting salary $475-525 per month. E. J. Platz, M.D., 153 Main St., Manchester, Conn.

NURSES: For new 75 bed general non-profit hospital. Resort area. Contact Administrator, South Coast Community Hospital, South Laguna, Calif. HYatt 4-8501.

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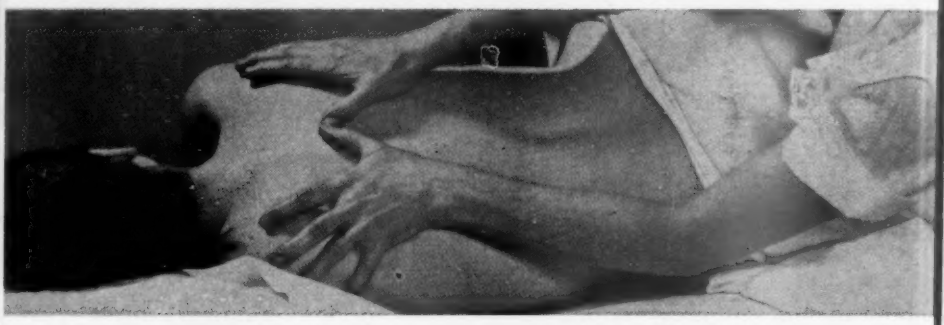

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opening for obstetrical and general duty RNs in accredited hosp. which is situated in a growing and thriving community with ideal climate. Salary range $300-400 mo. for 44 hr duty. Liberal personnel policies. Sick lv plan with 6 holidays per yr. Also we pay differential of $10 extra PMs. If interested please contact Administrator, Clovis Memorial Hospital, Clovis, N. Mex.

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NURSES, NURSES, NURSES: Wherever you are Best Wishes for the Season from all of us at the Los Angeles County General Hospital from Betty Hartwig, whose address is 1200 North State Street, Los Angeles 33, Calif.

OBSTERICAL INSTRUCTOR: A position is open at Los Angeles County General Hospital for an Obstetrical Instructor with a degree and exper. in teaching obstetrics. Sal. begins at $545 mo. Write: Betty Hartwig, R.N., Los Angeles County General Hosp. Box 1311, 1200 North State St., Los Angeles 33, Calif.

OPERATING ROOM NURSES: 250 bed hospital, salary based on experience in operating room nursing, call time additional, rooms available in Graduate Nurses Residence if so desired. Apply Dir. of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

OPERATING ROOM NURSES: 160 bed general hospital located in a beautiful residential section along the North Shore of Chicago. Starting salary $390 for days, $420 for evenings, 40 hr. wk. Modern ranch style nurses' homes with attractively furnished private bed rooms. Contact Personnel Director, Highland Park Hospital Foundation, Highland Park, Ill.

OPERATING ROOM SUPERVISOR: Experience desirable. Sick leave and annual vacation. Retirement benefits available. Salary open. Apply Administrator, Robinson Memorial Hospital, Ravenna, Ohio.

OR AND GENERAL DUTY NURSES: New 65 bed hospital, College town, to be opened early 1961. Contact Director of Nurses, Hillcrest General Hospital, Silver City, N. M.

OR & STAFF NURSING: Active 100 bed children's medical center. University affiliation. Good personnel policies. Apply Director of Nursing, St. Christopher's Hospital for Children, 2600 N. Lawrence St., Philadelphia 33, Pa. Telephone GA 6-5600.

OPERATING ROOM SUPERVISOR: 238 bed JCAH approved hospital. Intern, Resident and Nursing Education programs. Candidates with BS degree preferred. Apply to Mrs. Virginia Krahl, Dir. of Nursing Service, Santa Barbara Cottage Hospital, 320 W. Pueblo St., Santa Barbara, Calif.

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Nursing, Children's Hospital, 2125 13th St., N.W., Washington 9, D.C.

PSYCHIATRIC NURSES: As supervisors, head nurses and staff duty nurses in 250 bed general hospital. Liberal personnel policies, 40 hr. wk., other fringe benefits. Rooms available in Graduate nurses residence if so desired. Apply Director of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

PSYCHIATRIC SUPERVISOR: Supervisor for new 50 bed psychiatric wing in 525 bed private general hospital. To open approximately April 1, 1961. Position available now. Top salary and fringe benefits. Excellent opportunity for R.N. with degree and experience in psychiatric nursing. Write Personnel Dept., Sutter Community Hospitals, Sacramento, Calif.

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REGISTERED NURSE: For Intravenous Therapy and Blood Bank, no experience needed, we train you. Pleasant suburban community, 25 miles from New York City, 25 bed general hospital, 40 hr. wk., $335 per mo. regular increments, living facilities available if desired. Call or write Director of Nursing White Plains Hospital, White Plains, N.Y.

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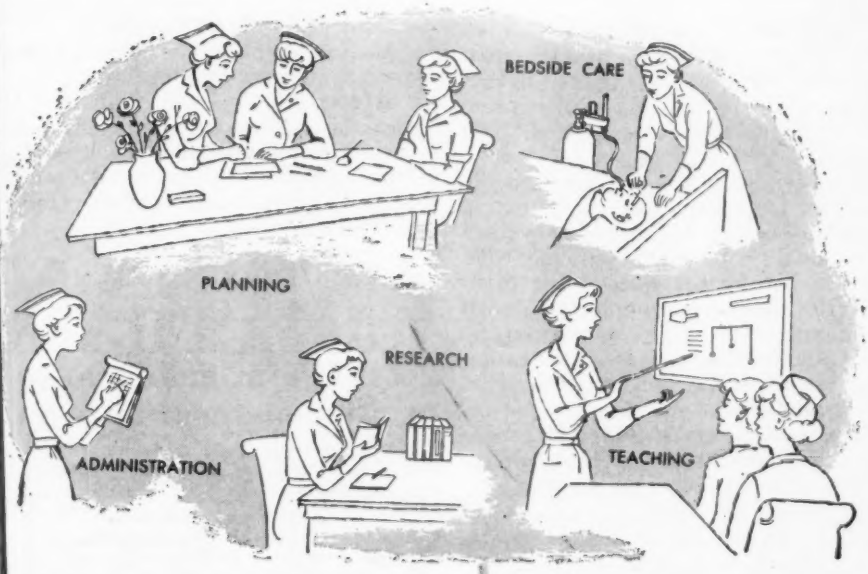

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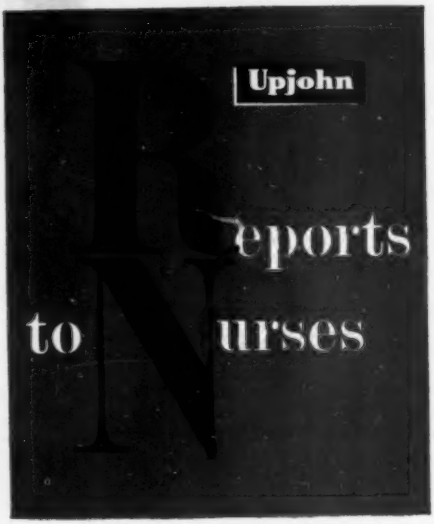

New formulation combines corrective and symptomatic therapy of premenstrual tension.

Fifty to seventy per cent of menstruating women suffer from premenstrual tension. Many of them either do not know what their trouble is, or hesitate to say much about it even if they do know.

The syndrome is recurrent, and the pattern is surprisingly consistent in any individual. Many patients have emotional symptoms as their chief complaint, but further questioning often reveals additional complaints associated with water retention and congestion. And further, patients may mention any one of several symptoms—fatigue, lower abdominal pain, leg ache, or insomnia—as the major complaint; some may go through a list of ten or twelve, all described as equally annoying.

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In spite of this range of symptoms, a single factor, hormone imbalance, appears basic to the syndrome. The signs and symptoms of this imbalance suggest an excessive estrogen effect related to an endogenous progesterone deficiency. Salt and water retention, autonomic and vasomotor instability, lower abdominal pains, and scanty menstruation, as well as evidence of poor luteal function, all seem to implicate a progesterone deficiency.

NEED TO CORRECT CAUSE AND RELIEVE SYMPTOMS

But even though progestational therapy may eventually correct this hormonal imbalance and ameliorate the premenstrual syndrome, simultaneous employment of symptomatic measures offers the advantage of immediate relief. Thus, effective treatment of the entire premenstrual tension syndrome should logically include correction of underlying hormone imbalance, relief from edema, and relief from nervous tension and anxiety.

CYTRAN PRESENTED AS MORE COMPLETE THERAPY

Cytran* is being offered to physicians as a treatment for the entire premenstrual tension syndrome. Because Cytran contains the new progestin, Provera†, the probable *cause* of the syndrome (hormonal imbalance) may be corrected. Symptoms such as abdominal discomfort, shakiness, and fatigue, incompletely controlled by mere symptomatic treatment, may now be effectively relieved. And while Provera in Cytran works to effect a restoration of hormonal balance, an effective diuretic (Cardrase†) and a mild tranquilizer (Levanil†) offer rapid, symptomatic relief.

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REGISTERED NURSES: General Duty 40 bed hospital, college town, resort area, above average salary, liberal personnel policies include 40 hr. wk., Social Security, meals, laundry. Apply Administrator, Ripon Municipal Hospital, Ripon, Wisc.

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REGISTERED NURSES: 88 bed modern JCAH general hospital, liberal personnel policies, starting salary $300. $20 differential evenings or night. 40 hr. wk., college town, 40,000 population, ideal climate, picturesque mountain scenery. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, N.M.

REGISTERED NURSES: For general duty in 89 bed general hospital, located in central Calif. General duty salary $320 to $340, shift differential for evening and night, 40 hr. wk., excellent fringe benefits. Write Administrator, Mark Twain Hospital, San Andreas, Calif.

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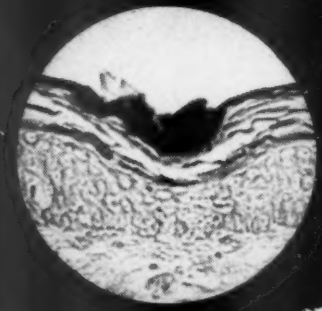

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1. Poor, H. J.: New York St. J. M. 60:2863, 1960.
2. Riese, H. F., et al.: J. Nutrition 66:345, 1958.
3. Smith, L. W., et al.: Amer. J. Med. Sc. 237:600, 1959.
4. Nutrition Reviews 17:136, 1959.

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